Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INTEGRA SPECIALTY GROUP, P.A. 517 N. CARRIER PARKWAY, SUITE G GRAND PRAIRIE, TX 75050	MFDR Tracking #: M4-11-0158-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: OLD REPUBLIC GENERAL INSURANCE Box #: 42	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Per MAR Fee Guidelines"

Amount in Dispute: $692.80

PART III: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this dispute.

Response Submitted by: N/A

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/24/2009	97750-FC	N/A	$346.40	$0.00
1/26/2010	97750-FC	N/A	$346.40	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.3 sets out the guidelines for communication between health care providers and insurance carriers.
3. 28 Tex. Admin. Code §134.204 sets out the medical fee guidelines for workers' compensation specific services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 1/12/2010 for date of service 11/24/09

- 45 – Charges exceed your contracted/legislated fee arrangement.

Explanation of benefits dated 8/19/2010 for date of service 11/24/09

- 45 – Charges exceed your contracted/legislated fee arrangement.
- W1 – Workers compensation state fee schedule adjustment.
- BL – This bill is a reconsideration of a previously reviewed bill.

Explanation of benefits dated 8/12/2010 for date of service 1/26/10

- W1 – Workers compensation state fee schedule adjustment.

Issues

1. Did the insurance carrier process the medical bills with sufficient, specific detail to allow the provider to easily identify the information required to resolve the issue and did the respondent submit a copy of a contract or any information to support that a contractual agreement exists between the parties to this dispute?
2. Does the requestor's documentation support the services billed?
3. Did the requestor submit any information that the medical bill for date of service 1/26/2010 was submitted in accordance with 28 Tex. Admin. Code §133.20 and did the requestor submit the medical fee dispute in accordance with Rule §133.307.
4. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits dated 1/12/2010, the carrier reduced the medical bill for date of service 11/24/2009 because "Charges exceed your contracted/legislated fee arrangement". 28 Tex. Admin. Code §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The division finds that the denial reason is generic because it does not identify whether a contract was accessed, nor does it identify the network if indeed a discount was taken due to a contract. The respondent did not clarify or otherwise address the 45 claim adjustment code upon receipt of the request for dispute resolution. For this reason, the division finds that the 45 claim adjustment code is not supported.
2. The requestor billed CPT code 97750-FC (physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes) for dates of service 11/24/2009 and 1/26/2010. For date of service 11/24/2009 the requestor billed 16 units of CPT Code 97750-FC and submitted the original EOB which supports that carrier denied the service with above reason code "45". The reconsideration EOB supports that the carrier paid $346.40 upon reconsideration and added reason code "W1". The requestor is seeking an additional $346.40 for this date of service. Pursuant to rule §134.204(g) The following applies to Functional Capacity Evaluations (FCEs). FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. The documentation the requestor submitted to support the billing is reviewed. It consists of 11 pages of an ERGOS assessment report including performance vs. job requirements, strength testing, range of motion, job assessment and grip exam. None of the documentation supports how much time was spent on each of the performance test measurements. The supporting documentation includes "start time 11:30 AM" but does not give a specific time for each performance test or measurement. Pursuant to rule §134.204(b)(1) Payment Policies Relating to coding, billing, and **reporting** for workers' compensation specific codes, services, and programs are as follows: Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules. Therefore, the documentation does not support the requestor's billing of 16 units of CPT code 97750-FC for date of service 11/24/09 and additional reimbursement is not recommended.
3. For date of service 1/26/2010, the requestor billed 8 units of CPT Code 97750-FC. The EOB submitted for this date of service supports that the insurance carrier paid $12.80 with reason code "W1" and the requestor is seeking an additional amount of $346.40 The requestor's documentation for this date of service consists of 14 pages of muscle testing, strength testing and grip exam. The documentation does not support how much time was spent on each of the performance test measurements. The supporting documentation includes "start time 1:45pm" but does not give a specific time for each performance test or measurement. Therefore, the documentation does not meet the requirements of rule §134.204 and does not support the requestor's billing of 8 units of CPT code 97750-FC for date of service 1/26/2010. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	6/16/2011 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.